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LOCAL HEALTH COUNCILS: THE CONSUMERS' VOICE*

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The voice of the consumer in the health service was given statutory recognition for the first time by the invention of local health councils whose sole function is to represent the interests of the public in the health service. Health councils were set up in Scotland in 1975 (they appeared a little earlier as community health councils in England and Wales), following the reorganisation of the health service. They have no executive power; they can offer advice. There are forty-eight such bodies with memberships varying from twelve to thirty-one, and representing populations ranging from 6,690 to 476,635.

The bodies charged with receiving and taking account of the health councils' advice are the fifteen health boards. Each health board is responsible to the Secretary of State for the planning and management of all health services in its area. The boards took over in 1974 the functions of outgoing regional hospital boards, hospital boards of management, executive councils and local authority health committees. A single body and one-tier system thus replaced a tripartite and partly two-tier system. For purely administrative purposes some boards have constituted "management districts" run by district executive groups, composed of four senior officers, and responsible to an area executive group at board level.

The number of health councils in a board area varies considerably. The Orkney, Shetland and Borders health boards have only one council each, whereas there are eight in the Highland board's area. Decisions as to number and geographical boundaries were made by health boards using a variety of criteria and

bearing in mind the administrative structure they had already adopted. Where management districts had been established, the precept usually followed was that there should be at least one local health council to each district. Since local authority district boundaries were taken into consideration when management districts were set up, there is usually some clear relationship between local health council and local authority boundaries.

Until reorganisation, the system had included a substantial number of lay participants. Health councils were in part an attempt to compensate for the reduction of lay involvement in health service management at a time when a movement towards participation was much in vogue. Health councils could also be regarded as a gesture towards those concerned that centralisation would increase the gap between the governors and the governed. The rationale for national health service reorganisation was managerial efficiency, and the health councils have been cited as one of the "imaginative participative mechanisms"¹ which might help to redeem the bureaucratic nature of the health service.

Local health councils were born into a largely unfavourable environment. In recent years participation and consumerism have made great strides elsewhere in Britain, but in Scotland there has been little demand for participation; and while one person in 92 of the population in Britain is a member of the Consumers Association, in Scotland only one in 131 is a member. The Scottish consumer tends to be characterised by acquiescence, stoicism and, especially where the health service is involved, by gratitude. Dissatisfactions rarely get beyond the stage of grumbling. The chairman of the Scottish Consumer Council, Joan Macintosh, has stated that

Scottish consumers are less inclined than English consumers to exert themselves, either individually or in groups, against rising prices, monopoly exploitation or infringement of their legal rights.

One health council participant attributed this torpor to a peculiar "Scottish conservatism", and an activist on behalf of patients believes that "backwardness in claiming our rights" is due to a deeply rooted "fear of standing out from the crowd". The historian, T. C. Smout, recently described Scots as "suspicious of one another, conservative and inflexible".²

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Smout indicts the education system: "... the Scottish working class and middle class alike has been exposed for a century to a miserable education system . . . which believes that teaching consists of trying to smash facts into children."³ Another oft condemned influence on Scottish life is the restrictive legacy of Calvinism. Also, the established church in Scotland maintains an influence, especially in public life, not matched by its counterpart in England. Its ministers still tend to be accorded the status of "community leaders", and whilst many of them individually are innovative and decidedly not conservative in the peculiar Scottish manner, it would seem unlikely that this hierarchical set-up could encourage greater lay participation.

With these peculiar Scottish disadvantages, the Scottish health service consumer is in an even weaker position than patients elsewhere. The lowly status of patients has been well-documented and Margaret Stacey thus explains the dilemma:

There is first of all the difference in knowledge and skill between the doctor and the patient; the "competence gap". There is the fact that in general terms most patients are far less highly educated than doctors and do not readily treat them as social equals. The nature of illness itself is relevant. When ill, patients are not in a good position to argue; when well, they seem not to care.⁴

The public consistently records high levels of satisfaction with the health service. A recent poll showed 45% of those questioned to be "very satisfied" with the NHS and 39% were "fairly satisfied".⁵ Ann Cartwright, discussing patients' satisfaction with general practitioner services, judges that "... behind the satisfaction of most patients there lies an uncritical acceptance and lack of discrimination which is conducive to stagnation and apathy".⁶ The belief that the British health service is the best in the world tends to militate against any activity which might rock the boat. Within health service circles there is much stress on consensus and a naive faith in the possibility of a "best possible health service for the public". The existence of competing interests, professional or public, receives little recognition and, in a service where political decisions on allocation of resources have to be made, much play is made of the need to keep politics out of the health service.

The health service tends to be reluctant to give information about its policies even where decision-making is overt. While

health boards meet in public, decisions are made in private in committee. This makes it easy to dismiss critics as uninformed. Whilst other professionals — teachers, for example — are regarded as fair game for public criticism and it is the "done thing" to have views on how the education system should be run, the health service professionals are relatively little criticised and expert opinion tends to weigh heavily. When criticisms of health service provision are made, there is a tendency to make a special point of exonerating the staff; for example, "Despite heroic efforts by the staff it is still a depressing hospital", or, "Staff doing their best in very poor buildings".⁷ Former patients write letters to local newspapers expressing gratitude for the care received whilst in hospital. We cannot recall coming across a letter of thanks for a wonderful education received. Joan Macintosh judges that health councils will have an uphill battle "if Scottish laymen are ever to show the courage to stand up to the professionals".

The problems involved in getting a consumer body specially concerned with health services off the ground in such an environment were compounded by the fact that severe reservations existed within the health service itself about the introduction of such an innovation. Coming so soon after the upheavals of reorganisation, the prospect of an additional and particularly a new type of input which might further disturb the balance of power was viewed with some anxiety by many in the health service. Scepticism existed about the ability of such bodies to represent the interests of the public (which some saw as a responsibility of health board members). The disappointing performance of consultative councils in the nationalised industries was quoted as evidence that such a system could not work.

It was anticipated that local health councils would be "a pain in the neck", "a thorn in the flesh"; that they might be "too political" or provide a forum for grumbling and complaints. A frequently quoted administrative reason for not welcoming them was that health boards were already feeling the burden of having to consult "a myriad of advisers". An obligation to consult local health councils in addition to bodies such as professional advisory committees, local authorities and trade unions was seen as compounding existing difficulties.

Concern about a possible erosion of power of board members and of officers was implicit in the fear that local health

councils might trespass on the management role, and in the contention that they were being given too large or too vague a remit, or would fail to stay within it.

An important source of doubt emanates from a strongly-held view that the professionals know best about policy, and that, because of the complexity and technical content of planning and decision-making, local health councils composed of "lay people" and lacking "professional" advice could have little or no contribution to make. Some wondered why highly-paid officials were employed, only to have less knowledgeable persons monitor and question their work. In particular, planning and the assessment of the general quality and adequacy of services, which the Scottish Office had suggested might figure among the interests of health councils,⁸ were seen as professional and management preserves. The importance with which the medical profession a two- to a one-tier management system, the proposed health service is illustrated by the statement in the report of a working-party of doctors set up by the Secretary of State to consider the organisation of medical work in a reorganised service:

It is the profession that has the fullest knowledge about the present medical work of the health service, about current trends and about future possibilities. This information, and guidance on its interpretation, should, in our view, be the foundation on which policy and management decisions are made.⁹

Mr William Ross anticipated professional reservations when he observed in the course of the passage of the Bill that "the medical profession hold up their hands in horror when they hear about public participation".¹⁰

Not everyone, of course, was against the idea. To some who had strongly opposed the change upon reorganisation from a two- to a one-tier management system the proposed health councils represented some compensation for what they had valued in a lower tier; they were "necessary to take the place of old boards of management" since "reorganisation means the consumer is unrepresented". Lay participation in management such as had existed under the old system had not itself come under much criticism — it had had to be sacrificed to other goals. It was a form of participation the parameters of which were known and accepted by both laymen and professionals.

Dilys Hill has pointed out that in health service bodies "the dominant set of conventions come from the traditions of the medical profession and the full-time administrators", and

the lay members must work within a framework of accepted rules and procedures which they can do little to change . . . The members of the stage army are drawn into an efficient and self-perpetuating system which induces strong loyalties.¹¹

But to the more perspicacious the new form of participation conjured up the prospect of the involvement of a different sort of lay person, and in a different relationship with those operating the service. They foresaw a possibility that bodies of this kind could turn out to be "irresponsible", "merely anti-health board", or "only strident and destructive critics".

At best, local health councils were considered as potentially useful in pointing out gaps or specific problems about waiting or transport, as assisting with health education projects or explaining constraints to the public. It was not envisaged that they should be involved in decision-making concerning, for example, the definition of objectives or the allocation of resources. These were seen as management activities. Health board administrators, as was consistent with the conventional British image of the good public servant, whilst largely sceptical of the advantages to be gained, took the pragmatic attitude that "if Parliament has decided we are going to have local health councils, we must co-operate as best we can"; or, slightly more constructively, that now councils were to come they would try to "make them work".

Outwith the health service, voluntary organisations welcomed local health councils as an additional channel for involvement and influence in public life as well as an opportunity to further their objectives. The trade unions, though regarding health councils as a poor substitute for a health service run by elected bodies, were smarting under what they considered to be unfair treatment in the apportionment of health board seats. They were therefore keen to gain influence in the health council system and requested (and were granted, as unions south of the border were not), a specific allocation of seats on the local health councils. Others, particularly in the Labour movement, to whom reorganisation represented an erosion of "democracy", were interested to ensure that health councils, as

the only readily available compensatory element, were as effective as possible.

Since the legislation contained only very basic provisions relating to the health council system, much was seen to hang on subsequent ministerial prescription and guidance. Those interests external to the health service expressed views about the essential requirements to ensure that local health councils could operate effectively. The independence of health councils from health boards, and their provision with adequate powers and resources, were regarded as of particular importance.

When, therefore, the Scottish Office had to make firm decisions about the health council system, it was aware on the one hand of the "lobby" interested in ensuring that health councils were in a position to be effective as consumer bodies, and on the other of the anxieties and lack of conviction of many in the health service. Klein has drawn attention to the importance of organisational factors or bureaucratic politics in policy-making. It may be that the civil servants in this situation were "reluctant to risk a confrontation" with the health service interests, not necessarily because they agreed with them about health councils but because they put high value on maintaining good relations with them since they depend upon them for the day-to-day running of the health service and "as a form of investment for the future".¹² At any rate they managed to put together a set of prescriptions which on the face of it took care of the immediate anxieties of the non-health-service interests whilst leaving to the health boards considerable latitude to "contain" the health councils once they began to operate.

Fears about insufficient independence stemmed from a desire that health councils should have every opportunity of being "consumer" rather than "service" oriented. Members on both sides in Parliament had expressed anxieties on this score: there was a danger that councils would be "inseminated, gestated, produced and weaned"¹³ by the health boards; "sometimes consultative bodies turn out to be the creatures of the executive bodies they are supposed to advise".¹⁴ Such anxieties were met by allowing health boards relatively little control over the personnel to be appointed to health councils even though they theoretically appointed two-thirds of them.¹⁵

It was further decided that the post of secretary to local health councils should be open and not, as might have been the

case, confined to health service employees. Although employees of the health boards for salary and other purposes, secretaries are regarded as in the service of the local health council and accountable to it.¹⁶ Secretaries have come from a very wide variety of backgrounds, about a quarter of which might be labelled "health service". Some difference of opinion exists about the advantage or otherwise of a council having a secretary with a health service background. Did "knowing the ropes" — and in some instances the people — compensate for the possible disadvantage of having been "socialised" into the values and perceptions of the service providers?

When local health councils were under discussion, the ideal office for them was envisaged as a shop front in the High Street. Few achieved this, and most councils are located within health service premises, while half a dozen of the smaller councils operate from the secretary's home. These arrangements do not assist in making the councils accessible to the public and most have expressed disappointment about the extent to which they have been "used" by the public.

Lack of information about proposals and plans is often cited as a major obstacle to meaningful public participation in policy-making. Some attempt to preclude this was made in the regulations relating to health councils. These made it the duty of a health board

to provide each Council in its area with such information about the planning and operation of the health service in the area . . . as the Council may reasonably require in order to carry out its functions.¹⁷

Such a regulation is clearly open to interpretation, and health councils have enjoyed differential success with their boards over requests for information. One of the larger boards told the Scottish Office at the outset that it foresaw difficulty in fulfilling even "reasonable requirements" for information. A ministerial decision in England and Wales to give community health councils the right to non-voting "observer" membership of their Area Health Authorities (the lower of two tiers) considerably strengthened their powers of access to information. No similar right exists in Scotland.

In view of the more parsimonious resources afforded to community councils, it might well be construed that the Govern-

ment responded handsomely to fears that health councils would lack effectiveness on account of inadequate resources. Most health councils appear satisfied with their annual budgets which range from about £3,000 to £12,500. This enables them to employ a secretary, either full- or part-time, and most also to have secretarial help. The rest has to cover postage and telephone costs, members' expenses, publicity and other activities.

The satisfaction of health councils may be a realistic assessment of the balance of power rather than of the real cost of performing their function; but it may also reflect their perception of their task and of its relative value in the national health service. In our opinion health councils were given minimal resources for their work. They are as a David to the health board Goliath, and largely lack compensatory skills such as were possessed by the former. Certainly they do not approach being the "counter bureaucracies" considered necessary by Klein if the consumer's position in the national health service is to be strengthened.¹⁸

Although it went through the motions of ensuring that local health councils would be equipped with the necessary rights and resources, the Scottish Office provided minimal guidance about what the new bodies were really supposed to do and how they should go about it. It was

for each local health council to decide how best to fulfil its statutory role of representing the interests of the public in the health service in the district for which it is set up. In general it will review the operation of the health services and make recommendations for improvements and will otherwise advise the Health Board on any matters relating to the operation of the health service . . . It will consider questions at the request of the Health Board, the Secretary of State, or on its own initiative.¹⁹

Whilst this might appear satisfactory on paper, in practice most new health councils were at something of a loss. One member observed:

If local health councils are expected to become effective, the Home and Health Department would require to clarify the remit not only to the councils but to the health boards, district administrators, hospitals, doctors and all concerned. So far we seem to be operating in a cotton-wool limbo, left to find our own way and level.

One health board official observed that they seemed "mixed up about what to do". The Scottish Office failed to provide examples of what might be construed as "the interests of the public" — a matter not likely to be evident to most lay people in view of what we have described as the prevailing milieu into which councils were born. The relative power, interests and values of the various participants in the health service have been little rehearsed in public. Nor did they indicate whether "representing" entailed ascertaining the views of the public — as was made clear in the case of community councils — or whether they should construe themselves as inherently "representative". No "training" independent of what health boards chose to provide was arranged as was the case when the Children's Hearings system was introduced. Nor did the Scottish Office seem to have been prepared to emulate the arrangement made by the Department of Health and Social Security in England and Wales to provide initial support for councils by appointing independent advisers, part of whose job was "to offer informal advice to individual CHCs". Instead, it resorted to the more timid step of appointing as liaison officer for a period of six months one of its own officials. Even this was resented by health boards.

Beyond that the Scottish Office retreated from the scene, leaning heavily on the principle that "councils should look to district executive groups and, where appropriate, area executive groups for any advice, support and information they require".²⁰ Health boards readily accepted the emphasis on local health councils' relationships with district executive groups; some appeared to use such distancing from area level as one of the ways of keeping the councils within bounds.

It is our contention that much more vigorous and imaginative steps were necessary on the part of the Scottish Office to compensate adequately for the disadvantages likely to be encountered by statutory consumer bodies in the health service. They not only failed to inject adequate compensation; they additionally tried to head off any possibility of conflict, as also did other "establishment" spokesmen, by repeated references to the need for the relationship between board and council to be one of co-operation and partnership, by reminding local health councils (on the basis of doubtful fact) that they had "placed on them the responsibility to consider and take account of the problems of management", and by urging that criticism

be "constructive". Additionally, as had been feared by some in Parliament, councils were expected to act on occasion as a kind of public relations agency for the board by "assisting in interpreting the health board's objectives to the community".²¹

It may be that in the light of their perceptions of the attitudes of many in the service, the taking of such a line was considered essential by the Scottish Office if the local health council system was to get off the ground at all and not to be the cause of an unacceptable level of dissatisfaction on the part of health boards and their employees. At a gathering of local health council office-bearers, a senior official told his audience that the Department was trying to monitor the new system and to advise and guide behind the scenes. They were interested in what local health councils were thinking, but the health boards were "nervous" about councils communicating with the Department on purely local matters which were within the responsibility of the boards. There and elsewhere²² reference was made by the Department to the desirability of there being a national organisation of local health councils. Delegates were told that without a national organisation "the voice of . . . councils might go by the board in matters of national policy". Whilst making no secret of its desire to see the establishment of such a body, the Scottish Office regarded it as essential that any initiative should stem from the councils themselves. Although a substantial minority of councils were opposed to the move, a national association was inaugurated in September 1977. Despite approving objectives which include engaging in research, the provision of information, and the development and organisation of training, the councils were reluctant to accord the association more than minimal resources. This cautious approach mirrored earlier unwillingness on the part of councils to appoint full-time secretaries. We have no reason to believe that, in either case, this was due to Scottish Office parsimony. In fact their liaison officer chided one council for contemplating less than full-time staff.

Since consumerism was so little developed in Scotland, perhaps more consideration should have been given to the membership of local health councils. As it was, the members of the new bodies were expected to adopt a consumer perspective without necessarily having had a previous interest in it and certainly without any special effort being made to help them

develop such an orientation. The National Consumer Council has remarked on the tendency of members of consultative councils in the nationalised industries to "become identified with", and to sympathise too readily with their industries in the light of knowledge of the constraints and of the sometimes unjustified criticisms which they experience, thus being distracted from a single-minded pursuit of their own role.²³ The sources from which local health council members were recruited made such an occurrence more likely than it might otherwise have been, even given the general climate we referred to earlier. Apart from the third of the membership of each council directly appointed by the local authorities, just over one third were appointed on the nomination of voluntary bodies and about one eighth by trade unions; a further eighth were persons chosen by the health board itself because of their "special knowledge of the health service".²⁴

The members of this last-mentioned group were drawn overwhelmingly from the pool of one-time members of now defunct boards and executive councils; thus they had experience mainly of the problems of management. They also had know-how about how the health service works, which was potentially useful to local health councils; but a leap of imagination was required to move from a service to a consumer orientation. Nevertheless, the experience of these members seemed to be highly regarded by others on the new councils, and a disproportionate number from this group were appointed chairman or vice-chairman. That there were a considerable number of resignations of members of this group in the first year of the health councils' operation is perhaps indicative of the difficulty found in adjusting to a different role.

A similar shift in orientation may have been required of the voluntary sector nominees. A substantial proportion of these members came from organisations which had long-standing and close associations with the health service in a "helping" capacity, for example Friends of Hospitals and the Women's Royal Voluntary Service. This group may have been used to a perspective not necessarily reconcilable with consumerism. Only two persons came into this group of members through nomination by a consumer body.

The bodies from which members were drawn — which incidentally were very similar to those which suggested names

for health board appointments — strongly influenced the age, socio-economic class and sex composition of the membership. In practice, because bodies almost without exception nominated their own members, it was necessary to be a member of some organisation in order to be nominated; and indeed many members were office-bearers in their organisations. There is ample evidence to indicate that members of local authorities are more likely to be male, older and from a higher socio-economic class than the populations they serve; that more males than females join trade unions; that membership of voluntary organisations is a more middle- than working-class activity, and that there is a positive relationship between occupational status and leadership positions in voluntary organisations.²⁵

It is not therefore surprising that local health councils, like health boards and many other public bodies, are not "representative" of their populations in a microcosmic or "mirror image" sense. A survey of local health council members in Scotland undertaken by the authors in 1976 found that males outnumbered females by 3 to 2 — a more balanced sex representation than on most public bodies, and attributable to the fact that the voluntary organisation nominees, apart from those of the Church of Scotland, were largely female. There were no members under the age of 25, persons under 35 and over 70 were substantially under-represented (appointment of the latter having been prohibited except in special circumstances); and those between 45 and 69 were very much over-represented. 80% of the membership came within the non-manual category of socio-economic class while only 40% of the population of Scotland is so classified. Within the non-manual group a disproportionate number of members came from professional and managerial categories. And within the under-represented manual category, skilled workers accounted for 15% of the membership, semi-skilled and unskilled for only 3%. In fact, there was only one unskilled manual worker among the respondents in our survey. Whilst manual workers may be under-represented among respondents we know that many non-respondents were not in fact from this group. And whereas only 29% of the population of Scotland are owner-occupiers, 64% of the local health council membership fell into this category.²⁶ In these respects the membership of Scottish health councils is very similar to that of their English and Welsh counterparts,²⁷ though in Scotland there is a more marked

tendency towards maleness, greater age and higher socio-economic class.

Discrepancies of this nature between councils and the public in their districts are sometimes accepted as inevitable or even desirable. Members needed to be articulate enough to deal with people like him, said one official. But such a lack of "fit" does open councils to the criticism of not being "really representative": "The councils are being peopled with eager-beavers who do not represent the community"; "members . . . are not necessarily truly men-in-the-street citizens"; "the method of selecting members . . . does not in the end produce a representative cross-section". Criticisms of this kind can be invoked to devalue the advice of a council. And devaluation is thought all the more defensible if it appears that a council is not making strenuous efforts — resources or no — to consult "the public".

With little guidance to assist the health councils in working out their role, inevitably a variety of styles and interpretations have developed. Differences in councils' perception of role are apparent when asked by the boards for the public view. This can be illustrated by examination of councils' responses to the question of fluoridation of the public water supply. Health boards consulted health councils in the course of deciding whether to provide the funds should the water authorities (the regional councils) agree to fluoridation which was being pushed by the central government. As one health council said, this was an "explosive issue" since it appeared that more members of the public were willing to express views on this subject than on most health-related topics. In one way however, it was an issue only peripheral to the concerns of the health councils since the boards, like the councils, could only make recommendations; the final say rested with the regional councils.

Health councils were inundated with "anti" literature from the Scottish Pure Water Association, and "pro" literature from the dental interests. Debates were held in some areas with speakers from both sides. In one area, the health board specifically asked the health councils to ascertain public opinion, but elsewhere any decision to seek out the views of the public was left to the councils. Four or five councils sought the views of the public through the local press, one contacted voluntary bodies, and two held public meetings; the public meetings were

poorly attended and judged by the councils to be unrepresentative; one of the two councils involved in this exercise voted contrary to the vote of the public meeting.

Most councils, however, studied the evidence for and against and took a vote, slightly more councils coming down in favour of fluoridation than against. Some felt disquiet at voting on their own account. One council regretted that the timing of the consultation had prevented any testing of public opinion; and a number of council members personally in favour of fluoridation voted against in view of what they judged as public opposition to fluoridation. There was also some concern expressed over the local authority representatives voting by party line. In debates which resulted in a "pro" vote there was some element of the councils' regarding themselves as guardians of the public interest. Rather like MPs who take a liberal line on issues like capital punishment, some health councillors supported a leadership role while recognising that they were "in advance" of public opinion.

For the health councils, it had been a disruptive and perhaps instructive exercise. Not only did they have to give some consideration to the way in which they saw their own role in representing the interests of the public, but some indications of boards' perceptions of the role of health councils became apparent. One council chairman had judged the fluoridation question as "custom-built as an issue upon which the local health councils were ideally designed to advise area boards"; when the board voted in the opposite way he was convinced "that the views of the local health councils are not significant in the workings of the health service in this area" and resigned, taking along with him the vice-chairman and two members. One health board did not wait for the advice of its health councils before taking its decision, and in another area the health board asked the councils which had voted against to inform the board of the steps they had taken "to canvass opinion in this district" while those councils which had agreed with the board were not requested to supply this information.

As well as roles implying "leadership" or reflection of public opinion, health councils have been cast in the roles of helper, critic and apologist for the health boards. The roles of "helper" and "critic" to some extent overlap, but criticism is not always construed as helpful by officials who at times judge that it is

based on a less than full appreciation of the factors involved. It is not always possible to make criticism "constructive" and very easy to label it "unconstructive". The identification of "gaps" or deficiencies in service is widely agreed to be a legitimate function of local health councils. One council drew attention to the lack of a clinic facility which "had escaped the notice of those providing the service". Another identified a gap in provision in the shape of

support for [mentally handicapped] children under school-age and for their parents who tend to become isolated in the early and formative years after the hospital had completed its care and before the Education Service is able to cater for them.²⁸

This council has used its initiative "despite a rather discouraging reply" from the district executive group of the health board, to set up a working party composed of people within and without the health service to investigate the possibility for setting up a Centre for such children and their parents. It is, however, a frequent contention in health board circles that health councils "never come up with anything not already known by health board people".

One unequivocal example of a "helping" role was urged upon councils when health education began to be pushed. The Government's consultative document "Prevention and health — everybody's business" stated that "... local health councils have a special responsibility for developing the preventive aspects of their work".²⁹ The Scottish Health Education Unit and the Scottish Council for Health Education co-sponsored regional conferences designed for the health councils during 1977; these were entitled "Health Councils — A Role in Health Education". Health council delegates were told, "If local health councils ... perceive and understand the message of prevention and health, the contribution they can make to the health of the community will be immense".³⁰ Some health boards welcomed the idea that there was a role for health councils in health education "at the right cost". One official thought that involvement in health education "would give them something to do since they're here". Cynics might say that health education was regarded as a relatively harmless channel for the health councils' enthusiasm and energies.

Many health councils willingly accepted this role, believing

that this was "a field in which local health councils can hope to have some influence".³¹ Not all endorsed this view, and indeed some which did accept the emphasis on health education have been unable to find the mechanics necessary for putting this role into practice.

One of the earliest approaches to health councils came from the pressure group Action on Smoking and Health (ASH). About a dozen health councils subsequently banned smoking at their own meetings, several approached the local authorities in an attempt to restrict smoking on buses and in public places with little success, and one council asked the Red Cross to stop selling cigarettes in hospitals. One or two councils were worried about infringement of the smokers' liberty. Aberdeen local health council was particularly active on this issue and set up a working party "to deal with Aberdeen's easy-going attitude towards smoking in public places".³² By letter and personal approaches the working party persuaded about a dozen restaurants to offer non-smoking tables and others agreed to display a wall sign requesting customers not to smoke. The council distributed an ASH notice for display in tobacconists' shops pointing out the legal age requirement relating to the sale of cigarettes. The council is at present co-operating with other bodies (such as the health education department, community councils and the Medical Sociology Unit) in setting up a self-help group for smoking withdrawal problems.

Health councils have also considered the problem of alcoholism and several have assisted in getting local councils on alcoholism off the ground. A number are currently engaged in distributing Kidney Donor Cards. One council enlisted the aid of some 80 local employers and the community councils and have now distributed 17,000 cards. The secretary of this council found that in this exercise they were tapping "a terrific fund of public goodwill" which supports any efforts directed towards health matters. Currently, some councils are supporting the new "Fit for Life" campaign by distributing leaflets or actively participating.

The ideals behind the specific activities councils have taken up in the interests of health education are lofty indeed. The Perth and Kinross council supported "encouragement of preventive measures and the development of a fully responsible attitude to health on the part of the individual".³³ Obviously,

this is a long-term goal and it is understandable if frustration sets in. A council which found suggestions on its role in health education "too airy fairy" found its three positive suggestions — for a "Stop Smoking" clinic, a clinic for alcoholics, and a display of health education literature in a new ante-natal clinic — immediately turned down by the board's health education officer. The councils' efforts in this area are not always welcomed and we were told by several senior health board officials that health education was a matter for the professionals.

Closely related to the "helping" role is the role of board's apologist which appears in the official guidance as "assisting in interpreting the Health Board's objectives to the community".

Local health councils may well find themselves in the role of explaining to the community why a particular proposal for improving the health service . . . cannot be implemented immediately.³⁴

When the health board have got advice and taken a decision, it is "up to the local health council to convey this to the populace" said one health board chairman. Although to our knowledge health councils have not all specifically rejected such a role, they have not espoused it either. Even where they have agreed with the board on an issue, they have been wary of giving the appearance of being "the board's mouthpiece".

There have been differences of opinion about the "level" at which local health councils should represent the interests of the public in the health service. Some consider that local health councils "need to know the minutiae; the health board needs to look at bigger things". Others consider that the councils have been too concerned with the "day-to-day running" of the service and with "trivial matters". "Local health councils should not be talking about the drains." Perhaps one factor militating against their looking at larger issues which have wider implications than for their own district, is that there is no provision for a consumer voice at area level, whereas professional advisory bodies to the board exist at both district and area level, the latter appearing to be regarded by the health board as the more important.

Visits to hospitals and other establishments have been a feature of the activity of most councils. This may have been a

means of getting to know the facilities; it is also reminiscent of the practice of boards of management and an activity which it was easy for health boards to suggest and arrange when health councils came into being. Perhaps partly as a result of this, but also because the quality of physical facilities is more easily assessed than parts of the service that are even more labour intensive, such as community nursing, local health councils were initially much concerned with hospital aspects of the service. There has been little, but perhaps growing interest in the general practitioner service, but like the health boards themselves, health councils are in a weak position *vis-à-vis* general practitioners because of their status as "independent contractors".

It was envisaged that health councils would become activated in the face of proposed changes of use or closure of health service facilities. Some councils got off to an active start as a result of having an issue such as this to deal with, and were indeed "envied" by others which found it more difficult to discover a role. In one or two cases councils which have agreed to the withdrawal of a facility have been out of line with organised public opinion and have found themselves "taking the stick" along with the board.

Where councils have disagreed with board proposals and some modification in plans has resulted it is, of course, unwise to attribute this to health council pressure. As Pickvance has pointed out it is insufficient to assume that "an antecedent event causes a subsequent event" and in particular that action or advice by advisers or external bodies is the cause of a particular decision on the part of the authorities.³⁵ Nevertheless, one health council was satisfied that its mobilisation of public opinion had resulted in the retention of a limited obstetric service in an outlying cottage hospital, when it was feared that this service would have been withdrawn completely. Certainly, the board's working party had agreed

that there were no valid paediatric or obstetric reasons for the continuation of the general practitioner obstetric unit . . . the only arguments in favour of the retention of the general practitioner obstetric unit were those based on social grounds.

The contention by health boards that removal of a facility as a result of centralisation will lead to the provision of a "better service" if at a greater distance and at greater inconvenience

to patients is a recurrent theme. The onus is on health councils to argue on social grounds and to point out that what may appear to be a saving to the health service is merely a shift of costs in the form of travelling expenses on to patients, relatives and staff. A difference in values becomes apparent on issues such as these between the providers of the service and the consumers. Some health councils have already recognised this divergence and we would contend that the possibility of denial of dominant belief in consensus in the health service is at least a basis for the growth of consumerism.

REFERENCES

1. Hunter, D., "The Reorganised Health Service", in Clarke, M. G. and Drucker, H. M. (eds.), *Yearbook of Scottish Government 1976-77*. Edinburgh 1976.
2. Smout, T. C., "The Scottish Identity" in Underwood, R. (ed.) *The Future of Scotland*. Croom Helm, London 1977.
3. Ibid.
4. Stacey, M. Paper given to conference "Representing the Patient", York 1976.
5. Political Social Economic Review, No. 12, December 1977.
6. Cartwright, A., *Patients and their Doctors*. Routledge & Kegan Paul, London 1967.
7. Annual Report of Renfrew District Local Health Council, 1976.
8. Scottish Home and Health Department, *The Constitution and Functions of Local Health Councils: A Discussion Paper*. July 1973.
9. Scottish Home and Health Department, *Doctors in an Integrated Health Service*. HMSO 1971.
10. Scottish Grand Committee, National Health Service (Scotland) Bill H.L. Consideration of Principle, 2 May 1972, col. 19.
11. Hill, D. M., *Participating in Local Affairs*. Penguin Books 1970.
12. Klein, R., "Policy Problems and Policy Perceptions in the National Health Service" in *Policy and Politics*, vol. 2, No. 3, March 1974.
13. Scottish Grand Committee, National Health Service (Scotland) Bill H.L. Consideration of Principle, 4 May 1972.
14. Parliamentary Debates Lords, Vol. 327, col. 1083.
15. NHS Circular No. 1974(GEN)38, Local Health Councils: Memorandum of Guidance.
16. NHS Circular No. 1974(GEN)90.
17. S.I. 1974 No. 2177 (S.300), The National Health Service (Local Health Councils) (Scotland) Regulations 1974.
18. Klein, R., "Health Services: The Case for a Counter Bureaucracy" in Hatch, S. (ed.), *Towards Participation in Local Services*. Fabian Society, 1973.
19. NHS Circular No. 1974(GEN)90.

20. SHHD letter to Chairmen of Local Health Councils, July 1975.
21. e.g. NHS Circular No. 1974(GEN)90; Scottish Council of Social Service, *Local Health Councils: An Account of a Conference*, 1973; and "The Health Service and the Community" in *The Hospital and Health Services Review*, vol. 71, No. 9.
22. e.g. Scottish Home and Health Department, *The Constitution and Functions of Local Health Councils: A Discussion Paper*, July 1973; NHS Circular No. 1974(GEN)90; and Scottish Home and Health Department, *The National Health Service and the Community in Scotland*, 1974.
23. National Consumer Council, *Consumers and the nationalised industries*. HMSO, 1976.
24. NHS Circular No. 1974(GEN)38, Local Health Councils: Memorandum of Guidance.
25. e.g. Royal Commission on Local Government in Scotland, 1966-69. Appendices, pp. 104-105; Royal Commission on Local Government in England, 1966-69, Vol. III, Appendix 7; Wirz, H., "Social Balance and new Town Organisations" in *Policy and Politics*, Vol. 2, No. 2.
26. Most of the data employed here comes from a survey of all local health council members carried out by the authors in 1976. The overall response rate was 66.4%.
27. Klein, R. and Lewis J., *The Politics of Consumer Representation*. Centre for Studies in Social Policy, 1976, Chapter 2.
28. Annual Report 1967/77 of the Western District (Greater Glasgow) Local Health Council.
29. *Prevention and health — everybody's business*, DHSS. HMSO 1976.
30. Report of the second regional conference on "Health Councils — a Role in Health Education". Scottish Health Education Unit, July 1977.
31. Second Annual Report of West Fife Local Health Council, 1977.
32. Second Annual Report of Aberdeen Local Health Council, 1977.
33. Second Annual Report of Perth and Kinross Local Health Council, 1977.
34. NHS Circular No. 1974(GEN)90.
35. Pickvance, C. G., "On the Study of Urban Social Movements". in *Sociological Review*, Vol. 23, 1975.